No. 84-1347

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

SEBASTIAN REBALDO, AS CHAIRPERSON OF THE BOARD OF TRUSTEES OF THE UNITED OPTICAL WORKERS INSURANCE FUND,
Petitioner,

VS.

MARIO CUOMO, GOVERNOR OF THE STATE OF NEW YORK; and DAVID AXELROD, COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF OF AMICUS CURIAE BLUE CROSS AND BLUE SHIELD OF GREATER NEW YORK

ROBERT A. BICKS
BREED, ABBOTT & MORGAN
153 East 53rd Street
New York, New York 10022
(212) 888-0800

Counsel of Record for Blue Cross and Blue Shield of Greater New York

OF COUNSEL:

ROBERT A. BICKS
ALAN C. DREWSEN
MICHIKO TAMATE
BREED, ABBOTT & MORGAN
153 East 53rd Street
New York, New York 10022
(212) 888-0800

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BRIEF OF AMICUS CURIAE BLUE CROSS AND BLUE SHIELD OF GREATER NEW YORK

INTEREST OF THE AMICUS CURIAE

Blue Cross and Blue Shield of Greater New York ("Blue Cross"), with the consent of all parties, submits this *amicus curiae* brief in opposition to the petition for certiorari. The decision below correctly construed ERISA[1] to avoid conflict

[1] The Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* (1982) ("ERISA").

with long-standing New York State policy to promote maximum availability of health insurance coverage at affordable rates.

A. The Purpose of NYPHRM

This proceeding seeks to preempt under ERISA one key provision of New York State's Prospective Hospital Reimbursement Method, N.Y. Pub. Health Law §2807-a *et seq.* (McKinney Supp. 1984) ("NYPHRM"), enacted in 1982. NYPHRM is a three year experiment in the comprehensive regulation of all financing for hospital inpatient services, which by its terms ends on December 31, 1985.[2] Adopting NYPHRM, the State's goal was to curb an unacceptable rate of inflation in the cost of hospital care, and at the same time to ameliorate operating deficits plaguing certain not-for-profit hospitals as well as distribute more equitably the burden of funding hospital services.

NYPHRM, for the first time, empowers the State to control all aspects of hospital care financing by regulating all sources of hospital revenue—particularly, the prices at which all persons may purchase hospital services. Before NYPHRM, the State controlled reimbursement to hospitals by the State Medicaid Program and by not-for-profit insurers such as Blue Cross. Also, pre-NYPHRM, the State regulated the charges that hospitals levied upon others. However, the State had no power over the largest single purchaser of hospital services, the federal Medicare Program. The upshot was that while the State had

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[2] Since NYPHRM runs out at year's end, now under consideration is whether to extend NYPHRM, as is or in some altered form, as well as alternative modes for financing hospital services in New York. On such issues, all interested parties have had their say, including State officials, legislators, commercial carriers, the State's Blue Cross plans, representatives of self-insured funds and other persons. If NYPHRM is allowed to expire and the financing of hospital inpatient services is determined pursuant to a new statute or returned to the methodology that NYPHRM replaced, this case will be moot. Likewise, if NYPHRM is to be extended, self-insured funds are urging the very change in NYPHRM that petitioner seeks to bring about through ERISA preemption. Such an amendment would also render the case moot.

long since decreed that Medicaid and Blue Cross reimburse hospitals at prospectively determined rates that accounted only for efficient performance of services, Medicare operated under no such discipline. Since the State had "no role in setting Medicare rates or handling Medicare payments . . . Medicare continued until 1982 to calculate hospital entitlements on the basis of costs computed at the end of each fiscal year." (App. 4.)[3] Because NYPHRM would not work unless Medicare reimbursement was brought under effective State regulation, the Legislature specified that NYPHRM could not take effect until the federal government agreed to adopt NYPHRM's methodology for Medicare reimbursement. 1982 N.Y. Laws 536 § 10(a).

New York thus applied for a Medicare "waiver," *i.e.*, authorization from the federal government to adopt NYPHRM as an experiment in Medicare reimbursement that was other than cost-based.[4] This waiver the federal government granted in December of 1982, and the State promptly proceeded to implement NYPHRM.

B. The Operation of NYPHRM

NYPHRM requires that the State "establish for each hospital an 'inpatient revenue cap', i.e., the maximum amount of inpatient revenue the hospital will be authorized to receive for services during a twelve-month period . . . ." (App. 7.) Each "general hospital is [then] required to establish a charge schedule sufficient to generate the inpatient revenue authorized by the revenue cap" (*id.*), taking into account that the Legislature had determined that certain payors were to receive a "differential" from the hospitals' gross charges. *See* § 2807-a(6)(b). At the same time, the Legislature concluded

[3] References are to the Appendix to the Petition.

[4] From the outset of Medicare, Congress had empowered the Secretary of Health, Education and Welfare to engage in "experiments and demonstration projects" to determine, *inter alia*, "whether the rates of payment or reimbursement for health care services, approved by a State . . . would have the effect of reducing the costs of such programs [Medicare] without adversely affecting the quality of such services." 42 U.S.C. § 1395b-1(a)(1)(C) (1982).

that all other payors, government-sponsored as well as private, were to pay the hospitals' established charges.

Thus, NYPHRM prescribes two levels of payment for hospital inpatient services. The first is based on each hospital's prospectively determined and efficiently incurred costs and applies to the federal Medicare program, the State's Medicaid program, corporations under Article 43 of the Insurance Law, which includes the State's Blue Cross Plans, and health maintenance organizations throughout New York. All other payors, such as commercial carriers, the State's Workers Compensation program, its no-fault insurance program, uninsured persons, and self-insurers such as the petitioner, pay the hospital's charges, which are set by statute at no more than 12-15% above such "costs." NYPHRM does not distinguish among charge-payors except to permit hospitals to continue any "negotiated payment rate determination systems [with] self-insured and self-administered groups" that were already in effect on May 1, 1982.

C. The Role Of Blue Cross In New York's Health Care Delivery System

Blue Cross is a not-for-profit health services corporation organized and operating for almost one-half century now pursuant to Article 43 (formerly Article IX-C) of the New York State Insurance Law. Blue Cross operates in a 17-county area that includes New York City and its environs. It provides hospital and health related benefits to some 9 million persons. An additional 4 million persons are covered by other Blue Cross plans that operate, also pursuant to Article 43, throughout the State.

New York State's Superintendent of Insurance and Commissioner of Health closely regulate all aspects of Blue Cross's operations. Thus, Blue Cross can offer no contract to subscribers without the prior approval of the Superintendent. N.Y. Ins. Law § 4308 (McKinney 1984). Similarly, Blue Cross rates or "premiums" to its subscribers must also be approved by the Superintendent. (*Id.*) Blue Cross can reimburse hospitals and

other institutional providers of care to subscribers only in precise accord with the reimbursement methodology prescribed by the Commissioner of Health under NYPHRM.

Since its founding in the 1930's, Blue Cross has been regulated by the State in such a manner as to further various community ends the State has deemed worthy. Included among these ends are the following:

> *First*, via its "open enrollment" periods, during which any person regardless of prior illness, physical condition, age or sex can obtain health insurance, and its Medicare supplementary coverage, Blue Cross—unlike commercial carriers—affords coverage at a uniform community-wide rate otherwise unavailable for high-risk individuals. Community-rated and Medicare supplementary coverage resulted in an operating loss for Blue Cross of $116,000,000 for the three year period ended December 31, 1982;
>
> *Second*, to provide hospitals needed operating funds, Blue Cross, but no charge-payor under NYPHRM, makes various interim payments to hospitals and otherwise provides their working capital prior to formal submission of claims. During 1983 the average outstanding balance in the advanced financing program was $180,400,000 which reduced Blue Cross's investment income by almost $20,000,000;
>
> *Third*, Blue Cross provides comprehensive coverage which, in turn, limits the amount of bad debts incurred by hospitals, bad debts which ran roughly $260,000,000 in 1982, the year before NYPHRM went into effect.

Recognizing the cost of such public functions as well as the fact that NYPHRM both decreased Blue Cross's pre-NYPHRM "differential" and otherwise increased Blue Cross's annual costs another $100,000,000 by requiring contribution to a hospital bad debt and charity pool, the Legislature deter-

mined that Blue Cross (along with Medicare and Medicaid) should purchase hospital services on a basis different from other payors.[5] Invalidation of § 2807-a(6)(b), as petitioner here seeks, would undermine this difference in treatment and leave one category of payors, self-insured benefit plans, free from any State regulation over the price at which they may negotiate for hospital services. Such consequence would disparage Blue Cross's ability to perform those community functions with which it has been charged.

Blue Cross, to repeat, is required to insure, on a "community-rated" basis, persons and groups that are, on the whole, older, poorer and less healthy than "experience-rated" groups and therefore constitute unacceptably high risks for other insurers. To insure all persons at a uniform and affordable "community" rate, Blue Cross relies on a subsidy which it collects from its "experience-rated" groups. Without a hospital payment differential, premiums to such groups could not be set at a level that would provide the necessary subsidy, without losing them to competitors who accept no such public responsibility. Typically, "experience-rated" groups are comprised of members who are employed, on the whole younger, and generally healthier than those who pay the community rate. Covering such "experience-rated" groups, Blue Cross includes a 1% subsidy for community rates in its retention formula used in calculating rates. Beyond that, all investment income earned on premiums paid by "experience-rated" groups goes to subsidize the community rate.

In short, for Blue Cross to continue to offer adequate protection to those whose needs are the greatest, it must depend upon, and also be attractive to, those groups whose needs are less. However, it is those "experience-rated" groups with lesser needs that, afforded a unique freedom from regulation and the right to negotiate hospital rates, would be most likely to move

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[5] As the district court concluded, "defendants and *amicus* have provided the Court with considerable justification for the payment rate differential established between ERISA plans and corporations such as Blue Cross." (App. 27.)

away from Blue Cross, thereby eroding the very subscriber base on which State policy has long banked in utilizing Blue Cross as its instrument for affordable community rates.

STATEMENT OF THE CASE

Petitioner is Chairperson of a self-insured and self-administered employee welfare benefit plan (the "Fund") regulated by ERISA. The Fund had no contracts in place with hospitals at the statutory cutoff date of May 1, 1982. As of the date it became a self-insurer on January 1, 1983, the Fund apparently entered into contracts with hospitals for inpatient services at rates below those prescribed in § 2807-a(6)(b). In December, 1983, almost one and one-half years after NYPHRM was enacted, this suit was commenced to preserve those contracts entered into after NYPHRM's deadline.

The district court for the Southern District of New York granted summary judgment for petitioner and declared § 2807-a(6)(b) to be preempted by ERISA § 514(a) "to the extent it prohibits a hospital from establishing inpatient charges for self-insured employee benefit plans covered by ERISA which are other than those authorized by Public Health Law § 2807-a(6)." (App. 45.)

Vacating the decision of the district court, the United States Court of Appeals for the Second Circuit held, in *Rebaldo v. Cuomo,* 749 F.2d 133 (2d Cir. 1984), that § 2807-a(6)(b) does not purport to regulate the structure, administration or benefits afforded by ERISA plans. Therefore that statute was deemed not to "relate to" ERISA plans and not preempted under ERISA § 514(a).

SUMMARY OF ARGUMENT

Petitioner has failed to show that the decision below conflicts with the decision of any other court of appeals or with applicable decisions of this Court. As a result, the petition for certiorari should be denied.

ARGUMENT

THE DECISION BELOW IS CONSISTENT WITH DECISIONS OF THIS COURT AND DOES NOT CONFLICT WITH DECISIONS OF OTHER CIRCUITS

The beginning point below was that, reading ERISA §§ 514(a) and 514(c)(2) together, "a state law must 'purport[ ] to regulate . . . the terms and conditions of employee benefit plans' to fall within the preemption provision" (App. 9). The court recognized the "broad and liberal construction" given the term "relate to" by the Supreme Court in *Shaw v. Delta Air Lines, Inc.*, 103 S. Ct. 2890 (1983) (App. 10) and that "ERISA preempts state laws that require or forbid the provision of a certain kind of benefit." (App. 11.) At the same time, the court went on to emphasize that:

> ERISA does not invalidate those State statutes whose effect on pension plans is simply tangential in nature. . . . This conclusion follows as a matter of common sense from the fact that ERISA plan members and managers are bound to engage in myriad transactions that Congress never considered when it drafted § 514. A preemption provision designed to prevent state interference with federal control of ERISA plans does not require the creation of a fully insulated legal world that excludes these plans from regulation of any purely local transaction. (App. 10.)

This conclusion applies with particular force where, as here, the "containment of hospital costs is an exercise of a State's police powers, which should not be superseded by federal regulations unless that was the clear intent of Congress." (*Id.*)

Against that background, the court held that "New York's decision to regulate the amounts hospitals can charge" was among those "state actions [that] may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." (App. 11.) Rejected because it "proves altogether too much" was the contention

that NYPHRM should be preempted because it increased the Fund's cost of doing business:

> The purchase of hospital service is like the purchase of public utility service, or of any other service or commodity whose price is controlled by the State. Insofar as the regulation of hospital rates affects a plan's cost of doing business, it also may be analogized to State labor laws that govern working conditions and labor costs, to rent control laws that determine what employee benefit plans pay or receive for rental property, and even to such minor costs as the Thruway, bridge and tunnel tolls that are charged to plans' officers or employees. In short, if ERISA is held to invalidate every State action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that never was contemplated by Congress. Where, as here, a State statute of general application does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated. (App. 12.)

Nor was whatever "indirect economic impact as may result from State control over hospital rates" deemed to "run counter to ERISA's aim of national uniformity in plan regulation." (App. 12-13.) For even without NYPHRM, "every hospital will be able to set its own rates for ERISA plans, and [petitioner] does not contend that these rates are, or will be, uniform, even as between hospitals in the same locality. Lack of uniformity is not a valid argument for preemption of New York's statute." (App. 13.)

A. The Decision Below Squares With Prior Decisions By This Court

In *Shaw v. Delta Air Lines, Inc.*, 103 S. Ct. 2890 (1983), for example, the Court held that subsections of two New York statutes relating to discrimination on the basis of pregnancy—the Human Rights Law and the Disability Benefits

Law—"relate[d] to" ERISA plans, the former because it required a specific structure in such plans and the latter because it required that the plans pay specific benefits. *Id.* at 2900. As noted by the court below, by way of contrast, NYPHRM regulates neither the structure of nor benefits to be provided by ERISA plans. In addition, while the purpose of the laws in *Shaw* was to regulate employment practices, which includes the provision of employee benefits, the purpose of NYPHRM is solely to regulate hospital costs and is in no way concerned with the structure, administration or benefits package of ERISA plans.

Similarly, unlike *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), no conflict exists between NYPHRM and federal law. In *Alessi,* the New Jersey Workers' Compensation Act, which prohibited the integration of pension benefits with workers' compensation awards, was deemed to be preempted because Congress had deliberately permitted integration. Hence, preemption was based on the narrow ground that there existed a "direct clash between the state statute and the federal policy to keep calculation of pension benefits a subject of either labor-management negotiations or federal legislation." *Id.* at 526 n.22.[6] In contrast, no federal policy can be derived from ERISA or any other federal law, with respect to the price payable by particular persons—ERISA plans or anyone else —for hospital inpatient services.

Also misplaced is petitioner's reliance on *Alessi* for the proposition that NYPHRM is preempted because through its regulation of hospital costs it "indirectly" regulates ERISA plans. (Petition, at 15-16.) As the Third Circuit found in *Alessi,* the "*only* purpose and effect of the [New Jersey] statute is to set forth an additional statutory requirement for pension plans." *Buczynski v. General Motors Corp.*, 616 F.2d 1238, 1250 (3d Cir. 1980), *aff'd sub nom. Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) (emphasis in original). Thus, the

[6] The Supreme Court in *Shaw* recognized that the *Alessi* decision rested narrowly on "the state law's frustration of [particular] Congressional intent." *Shaw,* 103 S. Ct. at 2900 n.15.

statute was "indirect" only in that the pension regulation was embodied in a workers' compensation law.

Here, New York State makes no attempt to "avoid[ ] through form the substance of the preemption provision." *Alessi,* 451 U.S. at 525. NYPHRM in form and in fact is a hospital cost containment statute. Nowhere mentioned is ERISA. It does refer to "negotiated payment rate determination systems between self-insured and self-administered groups"—but only to preserve those already in effect when NYPHRM was enacted. The fact is that the great bulk of ERISA plans are not "self-insured and self-administered groups," and many of the most significant "employee benefit plans" are exempt from ERISA. *See* 29 U.S.C. §§ 1002(1), 1002(32), 1003(b)(1).

B. The Decision Below Accords with Applicable Decisions from Other Circuits.

Thus, *Standard Oil Co. v. Agsalud,* 633 F.2d 760 (9th Cir. 1980), *aff'd mem.,* 454 U.S. 801 (1981), held that ERISA preempted Hawaii's Comprehensive Prepaid Health Care Act which, unlike NYPHRM, "directly and expressly regulates employers and the type of benefits they provide employees." 633 F.2d at 766.[7] The decision below acknowledged that "ERISA preempts state laws that require or forbid the provision of a certain kind of benefit" (App. 11), but correctly concluded that NYPHRM was not such a law.

There is likewise no conflict with *Hewlett Packard Co. v Barnes,* 571 F.2d 502 (9th Cir.), *cert. denied,* 439 U.S. 831 (1978). The California Knox-Keene Health Care Service Plan Act there preempted indisputably regulated ERISA plans. The California Act regulated "health care service plans" which were any plans providing health care services or insurance (including self-insurance) in return for a prepaid charge. As noted by the

[7] In fact, the State itself in *Agsalud* argued that the Hawaii Act did not "relate to" an employee benefit plan because it "pertain[ed] principally to benefits rather than administration." *Id.* at 765.

district court, the Act directly regulated "such areas as funding, disclosure, sales practices and quality of services." *Hewlett-Packard Co. v. Barnes,* 425 F. Supp. 1294, 1297 (N.D. Ca. 1977), *aff'd,* 571 F.2d 502 (9th Cir.), *cert. denied,* 439 U.S. 831 (1978).[8]

C. Without Record Basis Are Petitioner's Claims Of Adverse Impact

Finally, the petitioner, as well as the *amici,* fall back on the prediction of dire consequences for self-insurance if the decision below is allowed to stand. Thus, petitioner asserts that § 2807-a(6)(b) makes self-insurance unprofitable, that all previously self-insured funds will be forced to return to Blue Cross and will then be forced to accept state-mandated benefits they might otherwise not want to provide for their members. To this point the short answer offered below suffices:

> Where, as here, a State statute of general application does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated. (App. 12.)

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[8] Similarly wide of the mark is the suggestion that the "issues presented are related closely to those before the Court in *Metropolitan Life Insurance Company v. Massachusetts,* No. 84-325, *argument scheduled.*" (Petition at 1.) While both concern ERISA preemption, at this juncture the issues presented to this Court are otherwise dissimilar.

In *Metropolitan,* the question is whether a Massachusetts statute that requires insurance companies to provide specified medical benefits in all their contracts, presumably including those sold to ERISA plans, is saved from preemption by ERISA § 514(b), the insurance savings clause. In the present case, the Second Circuit determined that NYPHRM was not preempted by ERISA because the state statute did not "relate to" ERISA plans. Hence, even if this Court determines that the Massachusetts statute in *Metropolitan* is preempted, based on an interpretation of the scope of the insurance savings clause urged by appellant herein, such a decision would have no effect on whether § 2807-a(6)(b), which regulates the price hospitals can charge for inpatient services, "relates to" ERISA plans.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

BREED, ABBOTT & MORGAN
153 East 53rd Street
New York, New York 10022
(212) 888-0800

Counsel of Record for
Blue Cross and Blue Shield
of Greater New York

OF COUNSEL:

ROBERT A. BICKS
ALAN C. DREWSEN
MICHIKO TAMATE

APPENDIX

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1984

SEBASTIAN REBALDO, as Chairperson of the Board of Trustees of the UNITED OPTICAL WORKERS INSURANCE FUND,

Petitioner,

—against—

MARIO CUOMO, GOVERNOR OF THE STATE OF NEW YORK; and DAVID AXELROD, COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK,

Respondents.

IT IS HEREBY AGREED by and between the parties herein, through their counsel, that consent is given, pursuant to Rule 36 of the Revised Rules of this Court, for Blue Cross and Blue Shield of Greater New York to file a brief in this proceeding before the Supreme Court of the United States as *amicus curiae.*

Dated: New York, New York
March 6, 1985

SIPSER, WEINSTOCK, HARPER, DORN & LEIBOWITZ

By /s/
A Member of the Firm
Attorneys for Petitioner
380 Madison Avenue
New York, New York 10017
(212) 867-2100

ROBERT ABRAMS
Attorney General of the State of New York

By /s/
Judith A. Gordon,
Assistant Attorney General
Attorney for Respondents
2 World Trade Center
New York, New York 10047
(212) 488-2462